

<b>Case Number:</b>	CM13-0004792		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	03/31/2014	<b>UR Denial Date:</b>	07/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic surgery and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 48-year-old injured worker with the date of injury of July 24, 2012, who injured their right shoulder at work. MRI of the shoulder shows tendinosis and fraying of the supraspinatus and infraspinatus insertions associated with mild bursitis but no full thickness a retracted rotator cuff tear. There is a chronic long head of the biceps tear. No inflammation the biceps sheath or rotator cuff is noted. The patient has been diagnosed with biceps tendon rupture the right shoulder and tendinitis and impingement syndrome in the right shoulder. X-rays reveal a type III acromion. On physical examination the patient has pain to palpation of the anterior shoulder capsule and with cross chest maneuver there is pain. Patient has a negative apprehension test for instability. There is a positive Neer impingement sign. There is a positive Hawkins impingement maneuver. The patient has a limited range of motion of their right shoulder. At issue is whether shoulder surgery is medically necessary at this time.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **RIGHT SHOULDER ARTHROSCOPY, GLENOHUMERAL DEBRIDEMENT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-215.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-215.

**Decision rationale:** This patient does not meet established criteria for shoulder surgery at this time. Specifically, the medical records do not contain documentation of an adequate course of conservative care including physical therapy, NSAID medications, and a trial of a cortisone subacromial injection. In addition, the patient has no red flag indicators for immediate shoulder surgery such as complete rotator cuff tear with significant drop arm test and loss of motion. Established criteria for shoulder surgery have not been met. The request for right shoulder arthroscopy, glenohumeral debridement is not medically necessary and appropriate.

**RIGHT SHOULDER ARTHROSCOPY, POSSIBLE ROTATOR CUFF DEBRIDEMENT:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** This patient does not meet established criteria for shoulder surgery at this time. Specifically, the medical records do not contain documentation of an adequate course of conservative care including physical therapy, NSAID medications, and a trial of a cortisone subacromial injection. In addition, the patient has no red flag indicators for immediate shoulder surgery such as complete rotator cuff tear with significant drop arm test and loss of motion. Established criteria for shoulder surgery have not been met. The request for right shoulder arthroscopy, glenohumeral debridement is not medically necessary and appropriate.

**ASSISTANT SURGEON:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**POST-OP PERCOCET 5/325MG, QTY: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**INITIAL POST-OP PHYSICAL THERAPY, QTY: 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**COLD THERAPY UNIT, RENTAL/DAY, QTY: 7: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**ABDUCTION PILLOW SLING, PURCHASE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.